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## **Breaking the transactional mindset: A new path for healthcare leadership built on a commitment to human experience**

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### Abstract

Numerous health care publications have focused on the compelling need to improve patient experience and the associated improvements necessary to address workforce well-being. The COVID-19 pandemic exacerbated and illuminated long-standing problems in health care including workforce shortages, inequity in health care delivery outcomes, care provider burnout, and overall societal structural racism.<sup>1,2</sup> The Beryl Institute's Nursing Executive Council (NEC) manuscript *Rebuilding a Foundation of Trust: A Call to Action in Creating a Safe Environment for Everyone*<sup>3</sup> focused on actions and behaviours to heal relationships and build trust between care providers and leaders with commitments to safety, empathy, shared decision making, transparency, growth and development. Research studies abound offering new frameworks and interventions intending to strengthen systems of care that respect whole person needs. The nursing profession has always been anchored in holistic person-centered care yet continues to be challenged in work environments laden with fragmentation and barriers to human caring. The purpose of this paper is to review the dominance of transactional business mindsets and practices today that may foster those challenging environments and assert that the use of Service-Dominant Logic (SDL) demonstrates the importance of human relations in developing effective and sustainable organizational performance. Ultimately it can help us lead differently at all levels as we work to transform the human experience in healthcare.

### Keywords

Patient experience, nurse leadership, workforce well-being, trust, Service-Dominant Logic, leadership, human experience

### Background

In 2023, the National Council of State Boards of Nursing (NCSBN) found that one-fifth of U.S. Registered Nurses intended to leave the profession within the next five years in addition to the 100,000 RNs that left the workforce during the COVID-19 pandemic.<sup>1</sup> In response to growing concerns about the burnout of the healthcare workforce, national leaders have proposed plans to tackle the workforce issues.<sup>2</sup> However, there is concern that the current focus on health system operating margins is compromising the investment needed to transform the health care delivery system which will further exacerbate the very issues that thwart our ability to meet the needs of those providing and seeking care. Continued organization sustainability will require health care leaders, whether they are in communities, corporate suites, or operating Boards of Directors, to reframe their purpose and goals by endorsing human experience theory and practice.

### People demand change

Organizations committing to management systems grounded in continuous quality improvement and high reliability processes are more efficient, have higher productivity, safer environments and practices, and healthy team dynamics. Project-by-project, these organizations are breaking down silos opening opportunities for collaborative problem solving. Teams that embrace the use of processes, tools, systems, measures, and include those people closest to delivering and receiving care have shown sustained process improvement and positive gains. It is time for organizations to recognize and embrace the strategic value of human experience culture and weave it into their corporate culture for the benefit of those for whom they care, worker and consumer alike.

Outside the healthcare industry, delivering memorable positive consumer experiences is currently a transformational movement for businesses across all industries. Critical to this movement is the recognition that

employees are essential to creating experiences. Positive consumer and worker experiences increase business competitive advantages, respects the needs/desires of empowered consumers, decreases risks of obsolescence, increases consumer loyalty and brand equity, and promotes healthy financial bottom lines. Consumer expectations are mounting around corporate social responsibility to uplift communities by reducing poverty, racism, inequities in care, and reducing worker harm. In addition, there are expectations of improved business ethics and transparency in operations, increased corporate focus on conserving earth's limited resources, and reducing climate harm.<sup>4</sup> The ability to redesign and innovate corporate practices are now core requirements to allow organizations to develop new ways of performing.

Healthcare can learn from other business sectors which are designing dynamic experiential marketplaces. Leaders need to challenge prevailing traditional mindsets (both internally habitual and externally imposed) that no longer offer paths to sustainable futures. Experience strategy is often the missing link to sustainable healthcare services. As stated in the call to action by The Beryl Institute, it is time to “forge a new existence that begins with looking beyond the distinct silos of patient experience, employee engagement and community health, to focus on the common thread that binds each of these areas together—the human experience”.<sup>5, p.3</sup>

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Regular surveying of U.S. consumer healthcare service experiences was started at the end of 2019. The Beryl Institute - 2023 Ipsos PX Pulse survey<sup>6</sup> found that consumer perspectives of healthcare and human experience had significant room for improvement. First quarter results included consumer impressions of quality at 44% “very good” and “good”, and impressions of care experience at 68%. Comparing the average of the last three quarters to the three quarters of highest measures in 2020, quality perspectives are trending lower by 13% and experience perspectives trending lower by 9%. Top of mind for consumer respondents are costs of healthcare for items such as insurance premiums, drugs, and direct care costs. Access to quality care is next in importance to consumers and this is followed by perceptions of experience.

Around executive and Board of Director tables, discussions are dominated by critical appraisals and debates of financial performance and the actions required to improve operating margins. Organization performance

continues to rely upon traditional transaction thinking. For instance, healthcare is often thought of as one-way transactions from the organization to consuming recipients and that organizations control the “production of care” and its workers. However, the essence of healthcare delivery relies upon innumerable human interactions directly impacting business success. Communicating the importance of the human experience of care, which equally includes patients/consumers and healthcare workers, is essential to creating new understanding and behaviours supporting the dynamic and meaningful nature of caring work at its source.

The transactional paradigm of traditional organizational thinking is not conducive to meeting needs of healthcare providers. Perceptions of disempowerment, moral stress and injury, chronic excessive workloads, workplace incivility and violence, and being looked at as a financial expense are just some of the repeated concerns heard from the nursing profession.<sup>7-9</sup> Much has been written on the cumulative impact of nursing shortages, increased work absences, high rates of organization turnover, and lower interests to join the profession. Years prior to and during the COVID-19 pandemic, professional organizations and labour unions had been advocating for proper recognition of nursing work with increased compensation, and better working conditions that allow nurses to effectively function in ways that support their human experience thereby impacting the experience of others. The development of solutions to the current challenging healthcare workforce situation requires active participation of front-line staff working in partnership with leaders and regulators.<sup>10</sup>

### **Disrupting transactional mindsets with Service-Dominant Logic**

Since the early 2000's, as marketing field experts gained insights into service experience, relationships to consumers, and consumers' perceptions of value, Service-Dominant Logic (SDL) was introduced by Vargo and Lusch and the concept continues to evolve.<sup>11</sup> Its basic premise is that providers of service have knowledge, skill, and judgement to deliver what users/beneficiaries need, and an organizations' offerings shape value propositions to users. Users actively choose what they extract thereby creating value for themselves.<sup>12,13</sup> Generally, businesses are keen to create opportunities where consumers engage to co-create new offerings that increase the consumers' perception of value that, therefore, contributes to consumer loyalty.<sup>12</sup> Many healthcare organizations use this approach by actively including patient-family advisors on projects and committees.

According to FitzPatrick et al.<sup>14</sup> a continuum of relationality exists based upon the nature of interactions

between providers and consumers. It ranges from no relationality where informative interaction occurs and is characterized by co-ordination, to low relationality where communication occurs and is characterized by co-operation, and high relationality where dialogical interaction occurs and is characterized by collaboration and value co-creation for each party.<sup>14, p.467</sup> Due to the intimate therapeutic nature of interaction between healthcare providers and patients, their high relationality results in co-creation of value.<sup>12</sup> Through positive interactions, patients get personalized care supporting their life goals and, at the same time, providers get meaningful fulfilment and motivation from their efforts and altruism, therefore, both have gained value. However, either party can feel little or diminished value from relationships if they feel they have unfilled needs, feel disillusionment or potential harm.

Healthcare providers must perform within the rules and norms of organizations and professional responsibilities.<sup>13,15,16</sup> Within healthcare, divisions of specialty skills and knowledge requires collaborative work among healthcare providers to ensure that wide spectrums of needs of users can be met. In SDL, healthcare providers draw upon internal and external resources to facilitate service to patients. They differ in their individual internal resources such as cognition, memories, emotions, experiences, values, and external resources such as colleagues, available information, technology, and infrastructure. Healthcare organizations must work with practitioners to support both their internal and external needs making resources available to optimize delivery of care.

Patients also access internal and external resources influencing interactions with healthcare providers. Patients' internal resources might include things such as knowledge, memories, emotions, expectations, and external resources such as family and social networks, and finances. Outside of direct interactions there are multiple situations when

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value is being determined by patients and creating perceptions of experience. Some examples of this are in the use of pre-surgery preparation packages, using patient portals, and looking at on-line reviews and comparing experiences with other patients.

In summary, SDL offers a modernized view that value creation is iterative and dynamic. Figure 1 compares the transactional paradigm to SDL. Just as patients create value for themselves during interactions so are healthcare providers. Patients and families are not passive recipients. On the part of healthcare providers, so called intangibles (e.g., listening, empathy and compassion) are always part of the service interaction and are just as important as tangibles such as hands on physical care. Resources accessible to healthcare providers aid them in their presence with patients where they apply their skills, knowledge, and judgement in ways that generates value for patients and themselves.

**Organization context and calls to action**

SDL theory helps reframe a healthcare organization's focus, compelling a culture shift honoring and respecting healthcare providers' relationships with patients and families. It harmonizes with The Beryl Institute's declaration that "[the essence of healthcare] is fundamentally grounded in human beings caring for human beings".<sup>18, p.7</sup> Jackson and colleagues<sup>19</sup> meta-

**Figure 1. Transactional paradigm versus service-dominant logic<sup>13,14,17</sup>**

<b>Transactional</b>	<b>Service-Dominant</b>
Organization controls production and efficiency	Organization is dynamic and responsive providing resources to optimize performance
Economic measures rely on tangible outcomes	Value and economic measures rely on tangible and intangible outcomes particularly occurring through direct interactions
One-way delivery of service to patients	Dynamic exchange and co-creation of value between healthcare providers and patients
Organization offerings inherently provide value to patients	Patients determine the value of offerings within their own contexts
Mechanistic/functional thinking anchored in profits/margins and competition	Socially organized with "humanistic values of citizenship implied in reciprocity" <sup>14, p.469</sup>

narrative review of nursing work illustrates that nursing’s physical labour is often recognized but describes substantial shortcomings by organizations in accepting and appreciating the emotional, cognitive, and procedural demands of nurses’ work.<sup>19</sup> In principle, SDL legitimizes the physical, emotional, cognitive, and procedural labor of healthcare providers. This is consistent with the *Fundamentals in Care Framework* by Feo and colleagues<sup>20</sup> which describes nursing work as the integration between relationship, caring dimensions (physical, psychosocial, and relational), and organization context (policy and system) that are organically at play within complex adaptive systems.

Organizational cultural transformations facilitated by models of continuous quality improvement, patient safety, and professional practice have contributed to improved experiences for healthcare providers and patients. Although these models have different bodies of knowledge and priorities, they are not mutually exclusive and intersect where common goals of building organizational capacity exists. Figure 2 provides a snapshot of these models in relation to their unique benefits offered to healthcare providers.

In most health care organizations, quality improvement and safety transformations are strategic priorities with concomitant funding and regular attention around executive and Boardroom tables. Patient experience is often a true north organization priority with initiatives and measures wrapped together with quality improvement and safety reporting. In the ecosystem of healthcare, external funding and accrediting bodies raise the stakes for organizations stipulating outcome measurement and

reporting requirements to demonstrate compliance, performance transparency, and to compel accountability with consequences.

At times, nursing professional practice governance is not considered organization strategic priority. Legislation and regulations require medical professional governance and self-regulation in healthcare organizations, but this is not the case for other professions. To demonstrate an organization’s support of nursing practice, many organizations in the U.S. support work on American Nurses Credentialing Center (ANCC) Magnet or Pathways Recognition. This work helps create robust professional infrastructure. Supporting professional practice organization recommendations and recognition for nursing and medicine allows for a better understanding of what is important to the healthcare providers’ experiences. It also demonstrates a trust of professionals to partner in the management of quality and the effectiveness of practice. In addition, it helps organizations to determine resources and organizational structures needed to optimize service with patients.<sup>16,22,23</sup>

Human experience strategy with leadership and structure is well described by Carlson and colleagues<sup>24</sup> highlighting the central stage it should be taking in integrating the many organizational efforts to effect overall human experience improvements. Earlier years of strategic focus on patient experience made gains in customer service behaviours, established patient/family advisory councils and leader rounding, and developed patient experience surveys and reporting structures. However, when considering SDL there is a need to add healthcare provider experiences to improve ultimate performance.

**Figure 2. Comparing benefits to healthcare providers from quality improvement transformation, safety transformation, and professional practice governance**

Organization Transformation Foci	Core Purpose	Benefits to Healthcare Providers
Continuous quality improvement	Detecting and solving problems targeting process and system improvements that are driving out wastes such as errors, under-utilization of skills, unnecessary motion, waiting etc.	Ensures resources flow reliably, workflow is coordinated, goals are aligned, and roles are clear.
Patient safety	Detecting risks and filling gaps in processes, practices, and communications among interprofessional teams to deliver best practices consistently.	Team interdependencies are addressed with approaches, such as psychological safety, <sup>21</sup> enabling accountabilities and voices to act in anticipating and preventing errors.
Professional practice governance	Appraising and improving practice with infrastructures that communicate and mentor standards, reviewing quality among peers, facilitating on-going learning, designing care models, identifying provider resource needs, and generating professional knowledge	Shaping professional values, providing rules, standards, resources (e.g., learning, practice guides, role responsibilities), recognition, and pride.

## Leadership context and calls to action

The Beryl Institute's State of Human Experience 2023 survey, with 585 represented organizations and respondents with patient experience responsibilities across 25 countries, found that there is a perception that Boards of Directors are largely aware of experience efforts however only 27% believe their Boards provide substantial guidance and 34% provide some guidance.<sup>25</sup> To assist in changing this dynamic, healthcare providers and experience leaders should regularly share meaningful stories from patients and their care providers illustrating the tangible and intangible aspects of caring relationships. Human experience in action needs to resonate and help reshape framing of healthcare among top leaders. Educating Board members on concepts of human experience, the importance of shifting mindsets to include human experience theory, and the essential functions of professional governance will assist in moving this work forward. Human experience work needs leaders to create environments and provide resources that enable and empower professionals to actively engage in defining and managing professional practice in organizations. Flexible structures will be needed to allow staff the time to be involved in innovation work.

Leaders need competencies to develop protective work environments where there is relief from constant suffering, reasonable workloads, space for safe team relationships, positivity, and debriefing of stressful interactions to gain meaning and avoid cognitive distortions.<sup>26</sup> In addition, healthcare providers need support to develop skills of self-awareness and resilience to face inevitable adversities arising from relationships with patients and families. Resilience influences healthcare provider's motivations, self-regulation, capacity for compassion, feelings of effectiveness, and camaraderie.<sup>27</sup> In other words, resilience can positively affect how providers create and extract value from interactions with patients. Senior and frontline leaders need to develop their own competencies for resilience and act as role models to others. These important elements of an organization recognizing the importance of the human experience may be overlooked and/or actively dismissed in our current transactional organization paradigm.

### Implications for human experience research within organizations

Commonly used employee engagement surveys provide minimal insights into healthcare provider experiences with patients. On the flipside, patient experience surveys provide insights into perceptions of episodes of care such as effectiveness of communication, being treated with respect and dignity, and confirming if actions occurred to engage and empower patients. However, these surveys do not gauge if patients feel that value is sufficiently fulfilled.

Organizations provide consumers with offerings to help them reach their goals in ways that create value for them.<sup>28</sup> Measuring value creation at an organization level only provides insights into what guides or restricts value creation.<sup>28</sup> Broad feedback can be misleading since it is influenced by any number of touchpoints in the patient journey. What happens in interactions at the level of healthcare provider and patient level is invisible. It would be beneficial to research value creation and experience at the level of interactions.

Conroy and colleagues<sup>29</sup> are testing the *Fundamentals of Care Framework* with complexity science, graph theory and network analysis to understand from patients their interactions from the key dimensions of relationship (e.g., trust, focus), integration of care (relational, physical, psychosocial) and context of care (e.g., resources, leadership). The intention is to make "visible the otherwise intangible importance of the relationship between care providers and recipients".<sup>28, p.2910</sup> However, our assertion from SDL would suggest that measurement must also come from care providers to create a full picture of experience patterns.

Batat, an experiential marketing expert, suggests utilization of immersive research methods to elicit information about experiences and their meanings including projective techniques, ethnography, qualitative diary research, and interactive and subjective personal introspection.<sup>30</sup> All qualitative approaches that allow for individual expression and choice of words or images.

### Breaking the transactional mindset: A conclusion

Service-dominant logic offers healthcare leaders insights into the social, organic, and emerging nature of organizations. The transactional paradigm is stifling, if not diminishing, future sustainability and innovations needed to benefit patients and families, and healthcare providers. Too often we hear stories of experienced nurses losing joy and meaning at work as the focus is on interventions and the "numbers game" rather than discussing and valuing relationships and attending effectively to relationship stressors that accumulate and deplete people. We need to listen to novice nurses who feel they are not making a difference in the lives of patients because holistic care is never recognized, and they await the day when they might be recognized for "something big". Leaders need to be in service to healthcare providers who are the linchpin in service performance with patients and families. Top leadership has a strategic imperative to create new thinking, behaviours, and values that make space for concepts of service-dominant logic.

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### **Actions for leaders to influence uptake of Service-Dominant Logic and transform the human experience**

If we are to break the transactional paradigm in healthcare, there are several actions leaders can take to guide the organization toward the opportunities found in Service-Dominant Logic.

- **Curate and share stories particularly at C-suite and the Board of Directors level** regarding care journeys of patients and equally important the experiences of healthcare providers illustrating the iterative nature of relationships, and the determination of value by patients and healthcare providers including the tangible and intangible factors associated with service performance.
- **Increase supports and guidance of professional practice governance groups**, especially for caring professions that have higher intensity interactions with patients, to focus on demonstrating impact effectiveness, researching experiences of providers, and engaging in discussions regarding resource needs to deliver effective care.
- **Acknowledge that a commitment to human experience encompasses quality improvement and safety strategy** rather than it being a separate entity, and that patient and provider experience concepts need to be embedded in their approaches.
- **Equip leaders with development training** to assist in creating professional practice environments locally.
- **Provide leader development to create effective protective work environments** for teams, and skills and supports to develop resilience.
- **Increase use of research methods that are experiential/qualitative** to reveal meaningful insights into healthcare provider and patient relations and impacts on value perceptions and where improvement efforts are best spent.
- **Provide resources supporting healthcare provider engagements in cross-functional innovation work.**
- **Avoid narrative that frames and conveys healthcare providers as financial costs** and rather adopt narrative that indicates an understanding that

the experience of patients and healthcare providers must be considered and resourced for optimal performance.

While these actions begin the movement towards transformation, it remains critical that leaders at all levels continue to look for ways in which they can elevate and transform the human experience in healthcare. This list is not absolute, but a starting place for change. A commitment to listening to and acting on the voices of both those providing care and those seeking care every day is the critical first step on this journey of intention to change the mindset on how we lead healthcare today.

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